| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | TN4709 | A. BUILDING: _____ B. WING _____ | C 10/06/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NHC HEALTHCARE, FT SANDERS | 2120 HIGHLAND AVE KNOXVILLE, TN 37916 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| N 000 | Initial Comments<br><br>An investigation of complaint # TN00055358 was conducted on 10/6/2021 at NHC Ft. Sanders. No health deficiencies were cited in relation to the complaint and the facility was found to be in substantial compliance with the regulations under Chapter 1200-08-6, Standards for Nursing Homes. | N 000 | | |